BABY ANNIE:
An Investigative Review

OFFICE OF THE CHILD AND YOUTH ADVOCATE OF ALBERTA
APRIL 2014

Under my authority and duty as set out in the *Child and Youth Advocate Act*, I am providing the following Investigative Review concerning the passing of an infant who was, at the time, receiving services from the Government of Alberta. Consistent with section 15 of the Act, the purpose of this report is to learn from this tragic event and recommend ways of improving Alberta's child intervention system.

While this is a public report, my office has taken great care to protect the privacy of the family members of the infant involved. The names used in this report are pseudonyms and the report refrains from disclosing information that could be used to identify the infant or her family.

Accordingly, I would request that readers and interested parties, including the media, respect this privacy and not focus on identifying the individuals and locations involved in this matter.

This Investigative Review is about an infant of Aboriginal ancestry who died when she was just 14 days old. We call her baby Annie. Our thoughts and sincere condolences are extended to her family.

Tragically, the nature of Annie's death was such that it is uncertain what may have changed the outcome. Nevertheless, the circumstances around Annie's short life have illuminated several opportunities to strengthen aspects of the child intervention and health care systems, so that Alberta's children can be better protected and their families better supported.

[Original signed by Del Graff]

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CONTENTS

EXECUTIVE SUMMARY 5

INTRODUCTION 9
The Office of the Child and Youth Advocate 9
Investigative Reviews 9
About This Review 10

BACKGROUND 11
About Annie 11
About Annie's Family 11

HISTORY OF INVOLVEMENT WITH CHILD INTERVENTION SERVICES 13
Overview 13
Services Provided to Annie's Family 13
Freda's Pregnancy with Annie 17
After Annie's Birth 18
After Annie's Death 21

DISCUSSION AND RECOMMENDATIONS 22
Risk Assessment of Newborns in a Family with Active Child Intervention Services Involvement 23
Ensuring Balance in Delivering Child Intervention Services 25
Service Coordination and Information Sharing in the Assessment of Complex Families 26
Meeting the Needs of Infants Exposed to Drugs *in Utero* 29
Enhancing Parenting Assessments Used in Child Intervention Decision-Making 31

CLOSING REMARKS FROM THE ADVOCATE 34

APPENDICES 35
Appendix 1: Terms of Reference 35
Appendix 2: Committee Membership 38
Appendix 3: Genogram 40
Appendix 4: Summary of Significant Events 41
Appendix 5: Summary of Medications 42
Appendix 6: References 44

EXECUTIVE SUMMARY

Alberta's Office of the Child and Youth Advocate ("the Advocate") is an independent office reporting directly to the Legislature of Alberta, deriving its authority from the *Child and Youth Advocate Act*. Section 9(2)(d) of the Act states that, "...the Advocate may investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest".

In 2012, two-week-old Annie (not her real name)[1] was found by her mother to be unresponsive and not breathing. Emergency Medical Services transported Annie to the hospital where she was pronounced dead. The Office of the Medical Examiner classified her cause of death as "undetermined".[2] At the time of Annie's passing, her family was involved with Alberta's child intervention system. Annie's four older siblings were the subjects of Temporary Guardianship Orders[3] and were in care at the time of her birth. During her short life, Annie was in her parents' care. Annie and her family were of Aboriginal ancestry.

In September 2013, the Child and Youth Advocate advised the Minister of Human Services that an Investigative Review into the circumstances of Annie's death would be conducted.

Annie's parents, Freda and James' mutual involvement with Child Intervention Services began with the birth of their eldest child and it continued over the next eight years. Child intervention concerns were related to parental addictions, domestic violence, criminal activity, homelessness, neglect and inadequate supervision of their children. Annie's involvement with Child Intervention Services began when she was two days old.

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[1] All names used throughout this Investigative Review are pseudonyms. Section 15(3) of the *Child and Youth Advocate Act* states that a report must not disclose the name of, or identifying information about, the child to whom the investigation relates or a parent or guardian of the child.

[2] In Alberta, "undetermined" cause of death now encompasses those deaths previously classified as Sudden Infant Death Syndrome (SIDS).

[3] Under a Temporary Guardianship Order, the court awards custody and guardianship of the child to the Director for a specified period of time. The child is in the care of the Director and is placed in an approved placement. The Director shares guardianship with the parent/legal guardian of the child, however the Director takes precedence.

Prior to Annie's birth and after her birth, a number of professionals were involved in providing services to the family. One professional stated, "We all failed this baby – Why?"

The information gathered through the investigative review process revealed a number of key issues related to practices and processes in the child intervention and health care systems:

- **Risk assessment of newborns in a family with active Child Intervention Services involvement.** Annie was discharged from hospital into her parents' care, while her siblings remained in foster care. A Child Intervention file was not opened until concerns were reported from the community. Annie's interests may have been better served by conducting a risk assessment prior to her discharge from hospital or even by completing a safety plan prior to her birth.[4]
- **Ensuring balance in delivering child intervention services.** The issues of parental substance abuse and family violence were prevalent and longstanding in Annie's family. Throughout the history of the family's involvement with various support agencies, intervention largely centered on Annie's parents' alcohol and drug use. Family violence issues went largely unaddressed. An understanding of the cycle of violence and addictions was not explored with Annie's family. Interventions also focused almost entirely on Freda and James, rather than on the children or the impacts that exposure to violence and substance abuse had on them.
- **Service coordination and information sharing in the assessment of complex families.** Annie's family was involved with numerous systems and service providers. There was little sharing of information between service providers and little coordination of services amongst the agencies involved. Agencies worked independently in providing supports to the family. With little collaboration, those involved with Annie's family made decisions and took actions that were different than they otherwise might have been if collaboration and/or a joint response was encouraged and facilitated.
- **Meeting the needs of infants exposed to drugs *in utero*.** Freda and Annie were discharged from hospital 17 hours after Annie's birth. The development of a multidisciplinary protocol for newborns exposed to drugs *in utero* could assist in providing a coordinated response in situations such as Annie's. This would allow for professionals to work with a family to develop a care plan that ensures medical, child safety, addiction treatment and other support needs are met. In addition to improving services for infants who have been exposed to drugs *in utero*, it makes sense to prevent infant drug exposure in the first place. The ease with which Freda was able to refill multiple prescriptions over an extended period of time is of serious concern.

[4] In Alberta, the *Child, Youth and Family Enhancement Act* does not allow for the provision of services to unborn children.

- **Enhancing parenting assessments used in child intervention decision-making.** Both James and Freda underwent parenting capacity assessments during the year prior to Annie's birth. Assessments were limited to conversations, tests and questionnaires with James and Freda; and, information provided by the referring caseworker. Assessments did not draw from other information sources or involve observations of either parent with their children. Also, Freda and James were of First Nations heritage and one wonders how their parenting assessments might have looked had the assessment process taken into account indigenous cultural practices.

To address these issues and to help improve the effectiveness of Alberta's services to children, the Advocate makes the following **five** recommendations:

1. Child Intervention Services should institute policy that is proactive in planning for children and families when a newborn child is expected into a family that is receiving intervention services.
2. The Ministry of Human Services should work with Alberta Health Services to implement a provincial, multi-service response model that enables collaborative and joint response to families with at-risk children who are involved with Human Services and Alberta Health Services.[5]
3. The Ministry of Human Services and Alberta Health Services should establish policy and protocols to ensure sufficient information sharing[6] and a collaborative, timely (prior to discharge) response for infants at risk from Neo-Natal Abstinence Syndrome.
4. The College of Physicians and Surgeons and the Alberta College of Pharmacists should review the effectiveness of the Pharmaceutical Information Network to detect and flag multi-doctoring and potential safety concerns related to codeine and benzodiazepine prescriptions, with a view to preventing fetal exposure to these medications.
5. (a) Child Intervention Services should review how parenting capacity assessments are conducted across the province and implement policy that ensures parenting assessments are done in a consistent manner and are comprehensive in nature.

   (b) Child Intervention Services should ensure that parenting norms unique to First Nations and other cultural groups are incorporated into parenting capacity assessments.

[5] This recommendation is similar to one made by an expert panel in 2011 regarding the death of an infant. More detail is provided on page 28 of this report.

[6] Public bodies involved would likely be required to have a formal information sharing agreement and such sharing of information would have to be in compliance with the *Freedom Of Information and Protection of Privacy Act*.

In a previous Investigative Review, *Remembering Brian*[7], the Advocate recommended the development of guidelines regarding parental addictions and to fully examine and address the impacts that family violence and addictions have on children. The Advocate also recommended that a balance be struck between child-focused and family-centered approaches when delivering intervention services. Those recommendations are relevant in this review as well.

There are also opportunities for the Ministry of Human Services to continue broadening the scope of the Child Intervention Practice Framework as a means of driving policy and/or practice change that promotes engagement, critical thinking and incorporation of stakeholders in the information gathering and analysis process. In doing so, the safety of children will be enhanced.

[7] Office of the Child and Youth Advocate, 2013.

INTRODUCTION

The Office of the Child and Youth Advocate

Alberta's Office of the Child and Youth Advocate (the "Advocate") is an independent office reporting directly to the Legislature of Alberta. The Advocate derives its authority from the *Child and Youth Advocate Act*[8], which came into force on April 1, 2012.

The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act*[9] (the Enhancement Act), the *Protection of Sexually Exploited Children Act*[10] (PSECA), or from the youth justice system.

Investigative Reviews

Section 9(2)(d) of the *Child and Youth Advocate Act* provides the Advocate with the authority to conduct investigative reviews and states: "The Advocate may investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest."

Upon completion of an investigation under this section, the Advocate releases a public Investigative Review report. The purpose of an Investigative Review is to make findings regarding the services that were provided to the young person, and make recommendations that may help prevent similar incidents from occurring in the future.

An Investigative Review does not assign legal responsibilities, nor does it supplant or abrogate other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals, but to identify key issues along with meaningful recommendations which:

> *are prepared in such a way that they address systemic issue(s);*
> *and specific enough that progress made on recommendations can be evaluated;*
> *yet, not so prescriptive to direct the practice of Alberta government ministries.*

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[8] *Child and Youth Advocate Act*, S.A. 2011, c. C-11.5.

[9] *Child, Youth and Family Enhancement Act*, RSA 2000, c. C-12.

[10] *Protection of Sexually Exploited Children Act*, RSA, c. P-30.3.

It is expected that ministries will take careful consideration of the recommendations, and plan and manage their implementation along with existing service responsibilities. The Advocate provides an external review and advocates for system improvements that will help enhance the overall safety and well-being of children who are receiving designated services. Fundamentally, an Investigative Review is about learning lessons, rather than assigning blame.

About This Review

Freda (not her real name)[11] contacted Emergency Medical Services because her 14-day old daughter, Annie, was not breathing. An ambulance responded to the home and Annie was transported to the hospital where she was pronounced dead. The Office of the Medical Examiner classified Annie's cause of death as "undetermined"[12]. During her short life, Annie's family was involved with the child intervention system in Alberta. Her four older siblings were the subjects of Temporary Guardianship Orders[13] and were in foster care while Annie remained in her parents' care.

The Advocate thoroughly reviewed file information provided by Child Intervention Services. As a result, a preliminary investigative report was completed which identified a number of potential systemic issues that would benefit from an Investigative Review. In September 2013, the Child and Youth Advocate advised the Minister of Human Services that an Investigative Review into the circumstances of Annie's death would be conducted.

Terms of Reference for the Investigative Review were established, a copy of which is provided in Appendix 1. A team was assigned to gather information and conduct an analysis of Annie's circumstances through a review of relevant documentation, interviews and research. A number of individuals were identified as persons who would be able to provide insight into Annie's circumstances.

Annie's parents were contacted and declined to meet with the Investigative Review team.

A preliminary report was completed and presented to a committee of subject matter experts whose purpose was to provide advice related to findings and recommendations. The list of committee members is provided in Appendix 2. Committee membership was determined based on members' experience in best practices in Aboriginal health, clinical social work and death reviews. An Aboriginal Elder also provided guidance.

[11] All names used throughout this Investigative Review are pseudonyms. Section 15(3) of the *Child and Youth Advocate Act* states that a report must not disclose the name of, or any identifying information about, the child to whom the investigation relates or a parent or guardian of the child.

[12] In Alberta, "undetermined" cause of death now encompasses those deaths previously classified as Sudden Infant Death Syndrome (SIDS).

[13] Under a Temporary Guardianship Order, the court awards custody and guardianship of the child to the Director for a specified period of time. The child is in the care of the Director and is placed in an approved placement. The Director shares guardianship with the parent/legal guardian of the child, however the Director takes precedence.

BACKGROUND

About Annie

Annie appeared to be a healthy newborn infant. At birth, she weighed eight pounds and three ounces (3,713.8 grams). Her older brothers and sisters were excited about having a new baby in the family.

About Annie's Family

Born to a family of First Nations heritage, Annie had four older siblings (all under the age of seven): Katie, Kyle, Cindy and Matt. Annie's parents, Freda and James, also had children from previous relationships. Freda had two other children: Mike and Megan. James had five other children: Donna, Susan, Lori, Tim and Mark.[14]

Freda was adopted at a young age by relatives after her mother's death and she lived on Reserve until her late teens. Freda was the victim of physical and emotional abuse in her adoptive home which resulted in child intervention involvement. She did well in school and was very involved in her community until her teenage years when she left home and began using alcohol and prescription medications. Throughout her life, Freda suffered from depression due to unresolved trauma.

Prior to Freda's relationship with James, both of her children (Mike and Megan) were brought into the care of the Director within six months of their birth due to Freda's struggles with alcohol and drugs. They subsequently became subjects of Permanent Guardianship Orders.[15] Private Guardianship[16] was eventually secured for both children who were placed with their long-term caregivers.

James grew up in a large family in a remote community that followed Aboriginal traditions. He and his family trapped and hunted together. At age 14, James started drinking alcohol. Prior to meeting Freda, James was married for approximately 13 years and had five children. James said he used alcohol to cope with the breakdown of his marriage. He became transient and often had periods of unemployment.

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[14] A genogram of Annie's family is contained in Appendix 3.

[15] Under a Permanent Guardianship Order, the court awards guardianship of the child to the Director on a permanent basis. The child is in the care of the Director and remains in an approved placement. The guardianship of any former guardian is terminated and the Director is the sole legal guardian of the child.

[16] A Private Guardianship Order provides an alternative to adoption. A home study is completed and an application is made to the courts to appoint new guardians for a child. The child is no longer under the care of the Director.

James had custody of his five children from his previous relationship; but, the children lived with their mother sporadically. Over time Child Intervention Services responded to a number of reports alleging that James was not adequately supervising his children, and not providing consistently for their needs. There were also concerns about a lack of medical care for one of his daughters. James admitted that his drinking was affecting his children and, on a few occasions, he agreed to access community resources to address this issue.

Freda and James had a tumultuous, on-and-off-again relationship. They struggled with abusing prescription drugs and alcohol, and had involvement with both the child intervention and criminal justice systems.

HISTORY OF INVOLVEMENT WITH CHILD INTERVENTION SERVICES

Overview

Annie's involvement with Child Intervention Services began when she was two days old. Before Annie's birth and during her short life, her family had extensive involvement with Child Intervention Services. Annie's four older siblings were in the care of the Director under Temporary Guardianship Orders.[17] They remained in foster care for approximately three months after Annie's death and were subsequently returned to their parents' care under a six month Supervision Order.[18]

To understand the environment and circumstances of Annie's life, it is necessary to examine the child intervention services provided to her family.

Services Provided to Annie's Family

Freda and James' mutual involvement with Child Intervention Services began with the birth of their first child, Katie. It continued over the next eight years due to issues that included: parental addictions, domestic violence, criminal activity, homelessness, neglect and inadequate supervision of their children.

Within the first year of Katie's birth, there were five screenings undertaken by Child Intervention Services.[19] These resulted in two extended assessments[20] with the files eventually being closed with the reason stated as "no child protection concerns". Intervention concerns were related to domestic violence, inadequate housing and alcohol abuse by James and Freda. Freda was arrested for fighting while intoxicated and James was arrested for physically assaulting Freda.

[17] Under a Temporary Guardianship Order, the court awards custody and guardianship of the child to the Director for a specified period of time. The child is in care of the Director and is placed in an approved placement. The Director shares guardianship with the parent/legal guardian of the child.

[18] A Supervision Order is sought when mandatory supervision of a child and the person they live with is necessary to adequately protect the survival, security and development of the child. Intervention services are provided to the child and family/legal guardian through a court order. Guardianship and custody of the child rests with the family/legal guardian.

[19] A screening report is completed when a concern by the community or professionals is reported regarding possible risk to a child as per the *Child, Youth and Family Enhancement Act*.

[20] Extended assessment is required when further information is needed to gain a more complete understanding of the child's situation after the completion of an initial assessment. Further information may assist in determining the need for or type of child intervention services.

When Katie was 12 months old, Freda was arrested for shoplifting while Katie was in her care. Freda had stolen household items and medication (Robaxacet,[21] acetaminophen with codeine and cough syrup). There were also empty prescription bottles in her purse for Tylenol 3[22] and Bromazepam.[23] Katie was dirty, she had a cough and a serious diaper rash. At the time, Freda and James were caring for Katie and James' two sons (Mark and Tim) at a local hotel.

Katie was apprehended[24] and placed with James' mother in a rural community. Approximately one month later, Katie was returned to James' care under a six-month Supervision Order, with the condition that Freda would only have supervised visits with Katie.

During this period, Child Intervention Services received concerns that James was not meeting the medical needs of his daughter Lori, who was 16 years old at the time. In addition, a report was received that James was intoxicated while caring for Katie, Mark and Tim. James was subsequently arrested[25] and the children were placed with their paternal grandmother. Upon James' release from jail, the children were returned to his care. Freda was not in the family home during this time.

Freda and James had their second child, Kyle. Concerns were received about Freda's ability to care for Kyle. The assessor met with the family at the hotel where they were living. At this time, James and Freda had reconciled and they had five children in their care: Kyle, Katie, Mark, Tim and Lori.

Freda admitted to the assessor[26] that she was addicted to prescription drugs and alcohol, and indicated that she was agreeable to attending culturally-based addictions treatment. James admitted to using prescription drugs, but only those he obtained through a prescription (Tylenol 3 and Lectopam). A Supervision Order was granted for an additional six months.

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[21] Robaxacet contains an analgesic (acetaminophen) and a muscle relaxant (methocarbamol) for relief of back pains. http://www.backrelief.ca/back-relief-products/robax-oral-caplets/robaxacet

[22] Tylenol 3 is used to treat mild to moderate pain. Tylenol 3 works very quickly so those with addiction issues may be advised to take care with their dosing. Women who are pregnant or breastfeeding should not use Tylenol 3.

[23] Bromazepam (brand name Lectopam) is a benzodiazepine derivative drug used in the short-term treatment of anxiety or panic attacks or for premedication before surgery. http://en.wikipedia.org/wiki/Bromazepam.

[24] An Apprehension Order is sought when a child cannot be adequately protected in their family setting and is brought into the care of the Director.

[25] The reason for James' arrest was not documented on the intervention file.

[26] The family was very transient and would often move to different locations within the province which resulted in several different assessors and caseworkers being involved with the family based on the family's location.

James and Freda subsequently separated, and identified that domestic violence, drug abuse and alcohol abuse contributed to their separation. The children remained with James and caseworkers were satisfied that there were no child protection concerns.

Within a month, Child Intervention Services apprehended the children due to concerns that Mark and Tim were not attending school regularly. Assessors responded to the home and noted that there was no food in the home and the baby bottles were filled with water instead of milk. The four youngest children were placed in foster care and Lori was placed with her mother. James was described as uncooperative.

The children underwent a standard medical examination and Katie (about two years old) and Kyle (about one year old) were determined to be malnourished. Kyle was also found to be developmentally delayed. A Custody Order[27] was granted for Katie and Kyle. The older children, Mark and Tim, were returned to James' care.

Later, James obtained housing in his local community and Katie and Kyle were transitioned back to his care. Freda reunited with James and a three-month Supervision Order was granted regarding the four children in their care.

At the end of the Supervision Order the intervention file was closed because there were no reports of either parent consuming alcohol in the presence of the children.

Approximately three months after the intervention file was closed, concerns were again reported to Child Intervention Services that Freda was using drugs while pregnant and not adequately supervising Kyle. Freda and James had again separated. Freda admitted to the caseworker that she was abusing prescription drugs but stated that she was using fewer drugs since becoming pregnant. The assessment was closed because Freda said she would stop abusing drugs.

Approximately one year later, concerns were reported to Child Intervention Services and police regarding Cindy (James and Freda's third child), who was under one year old and in Freda's care. At this time, Freda was separated from James. It was reported that Freda was intoxicated while caring for Cindy. The matter was closed after James assumed care of Cindy.

Approximately one year later, Freda and James had their fourth child, Matt. Freda reported that she was homeless. At this time, Freda had care of Katie, Kyle, Cindy and newborn Matt. Freda and the children were admitted to a shelter but before an assessor could meet with them, Freda left the shelter and went to a hotel. Freda was subsequently asked to leave the hotel because she was intoxicated.

[27] A Custody Order is granted by the courts to provide the Director temporary custody and guardianship of the child until legal status can be determined. The child is placed in an approved placement.

A few days later, police were called to the family home to find Freda intoxicated and attempting to kick a sober caregiver (a paternal aunt) out of the home. Freda and James had again reunited. The police arrested James, who was intoxicated and attempting to hide from officers because of an outstanding fine related to impaired driving. Both Freda and James were uncooperative. The aunt agreed to stay and care for the children. The matter was opened to a safety assessment.[28]

The next day, an assessor[29] made an unannounced visit. The aunt was still caring for the children, but they were unable to wake Freda. The assessor returned the following day and found the children to be extremely dirty. There was no food in the home and Cindy had a diaper rash. Freda refused to attend addictions treatment.

An Apprehension Order was granted for all four children. However, when the assessor returned to the home to execute the Order, Freda and the children could not be located. James subsequently notified the assessor that, upon his release from jail, he had taken the children. He agreed not to leave the children unsupervised with Freda.

Later, Freda was arrested for stealing and resisting arrest while caring for two of her children. All four children were then apprehended. A nine-month Temporary Guardianship Order was granted and the children were placed with their paternal grandmother. Freda was incarcerated for a period of time.

The family was involved with two Aboriginal community service agencies that provided in-home support twice a week, parenting classes and support. After her release from jail, Freda had on-going involvement with monthly addictions support, attended parenting classes and met with a therapist regularly.

Both James and Freda underwent parenting capacity assessments.

The recommendations resulting from Freda's parenting assessment was that the children should not be returned to her care until she made "notable progress" in addressing her addictions, parenting skills, mental health and pattern of domestic violence with James. The assessment was completed four months prior to Annie's birth, and consisted of an interview and testing conducted during one appointment.

James' parenting assessment was completed nine months prior to Annie's birth, and was based on interviews and tests conducted over two appointments. The assessment noted that the children would be vulnerable for neglect in James' care unless he was open to changes related to his coping habits, parenting skills, addictions and his relationship with Freda.

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[28] A safety assessment is completed as part of an initial assessment to determine if a child is in need of protective services. Through the gathering of information and investigative interviews of family members, the need for further action is determined.

[29] For the next 17 months, up until Annie's death, the assessors, caseworkers, supervisors and manager providing services to Annie's family were located in the same office.

Freda's Pregnancy with Annie

Freda had regular contact with the two Aboriginal community-based agencies involved in supporting the family. During her first trimester, Freda made these agencies aware of her pregnancy. Child Intervention Services did not become aware of Freda's pregnancy until approximately one month prior to Annie's birth.

During the course of her pregnancy, Freda had four prenatal visits with an obstetrician. The recommended number of visits is normally between 12 and 14.[30]

Six months prior to Annie's birth, Freda was questioned by her obstetrician regarding her drug use. Freda stated that she was not using prescription medication or any other drugs. However, upon further review of medical information found on NetCare[31], the obstetrician found that Freda was prescribed large amounts of medication. The obstetrician left a phone message for Freda's primary physician expressing concern about Freda's drug use, but did not receive a response. Freda's primary physician was unaware of Freda's pregnancy because her prescriptions could be refilled without a doctor's appointment. The medications in question were prescribed for anxiety, insomnia and two injuries.

The obstetrician contacted the hospital social worker to express his concerns about Freda's use of prescription medications while pregnant. During this time, Freda was attending an addictions relapse prevention program, which she had previously completed twice.

Through the course of her pregnancy, 11 physicians prescribed medication to Freda. Close to 5,000 pills[32] were prescribed, including:

- Acetaminophen – caffeine & codeine;[33]
- Tylenol 3;
- Diazepam;[34]

[30] Alberta Health Services, 2013

[31] NetCare is an internal health information system for authorized users such as physicians and other health professionals.

[32] Information regarding the number of physicians and prescriptions prescribed was obtained during the Advocate's review.

[33] Acetaminophen, caffeine and codeine – this combination product is used to treat mild to moderate pain. It is recommended not to be used more than five days, unless directed by a doctor.

[34] Diazepam (Valium) is used to treat anxiety disorders. This medicine belongs to a group of medicines called benzodiazepines. It should be taken for short periods only, around two to four weeks. Continuous long-term use is not recommended. As well it should not be used by those addicted to drugs or alcohol. It is also not to be used while pregnant.

- Temazepam;[35]
- Lorazepam.[36]

A complete list of the medications prescribed to Freda is contained in Appendix 4.

After Annie's Birth

Annie was born after a full term pregnancy (41 weeks), weighing eight pounds and three ounces (3,713.8 grams). Labour and delivery were reportedly normal. Freda and Annie were discharged from hospital the following day, 17 hours after delivery.

An initial hospital examination by the pediatrician determined that Annie was a healthy infant. The pediatrician was not aware of Freda's prescription drug use and Annie did not show signs of suffering from drug withdrawal. Annie and Freda were discharged from hospital with the condition that Freda not breastfeed. Medical staff recommended that Annie see a pediatrician within six to seven days to monitor potential health complications.

On the day they were discharged from hospital, Child Intervention Services became aware of Annie's birth when an older sibling told a caseworker about a new sister. That afternoon, a meeting took place involving Freda and James, lawyers and child intervention workers. It pertained to Annie's four siblings, who were still in foster care. The meeting focused on the need for James and Freda to have clean drug testing and the potential for an application for Permanent Guardianship should James and Freda not follow through.

At this meeting, there was little discussion about Annie being in her parents' care and no additional services were implemented.

Seven hours after Freda and Annie were discharged from hospital, Child Intervention Services received a concern regarding Freda's ability to care for Annie. The concerns were related to Freda's use of sedatives, which would reduce her alertness and ability to respond appropriately should Annie suffer from drug withdrawal.

[35] Temazepam (Restoril) is used for sleeping problems and is to be used for seven to ten days. This medicine belongs to a group of medicines called benzodiazepines. It is habit-forming and should not be used during pregnancy or breast feeding.

[36] Lorazepam (Ativan or Orfidal) is used to treat symptoms of excessive anxiety. It belongs to the class of medication called benzodiazepines. It is an active medication that should not be taken during pregnancy or breast feeding.

Medical staff had recommended that the Alberta Vulnerable Infant Response Team (AVIRT)[37] complete an assessment. However, because Child Intervention Services was already involved with Annie's family, the matter was referred to the child intervention community office for further action.

The day after Freda and Annie were discharged from hospital, a Public Health nurse attended the family home. The nurse was not aware of Freda's prescription drug use or the potential health risks to Annie. This information was received by Public Health some time after the nurse's visit.

During the nurse's visit, Annie appeared to be in good health and Freda was bottle-feeding her.

Three days after Annie's birth, an assessor attempted a home visit but the family was not home. The following day, an after-hours worker completed a home visit and no concerns were noted.

Seven days after Annie's birth, the assessor met with the family. Drug testing for Freda indicated positive results for various prescription medications, including codeine. Freda told the assessor that she had been at a different hospital on the day of Annie's birth and that the medication was administered at that time.[38] Freda and James also informed the assessor that an appointment with the pediatrician was scheduled for the following week, nine days after Annie's birth. However, this Investigative Review found that no pediatric appointment was made for that date, but for six days later (i.e., 15 days after Annie's birth).

Freda and James cancelled a scheduled appointment with Public Health. However, Freda informed the assessor that she had taken Annie to the Public Health clinic and reported that Annie had gained one pound and two ounces (510.29 grams) and now weighed nine pounds and five ounces (4224.1 grams). The Public Health clinic later advised that Annie had never visited the clinic.

When Annie was nine days old, an in-home support worker was supervising a visit with Annie's siblings from their foster home and Annie seemed to be doing well. This support worker was the last professional to see Annie alive.

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[37] The Alberta Vulnerable Infant Response Team (AVIRT) is a collaborative response to assessing at risk infants who are under four months old. Alberta Heath Services, police and Child Intervention Services are working together to deliver this core service. AVIRT only assesses if there is no current involvement with Child Intervention Services. However, AVIRT may be a resource for a caseworker.

[38] Information obtained through the Advocate's Investigative Review established that Freda went to a different hospital five days prior, requesting to be induced and requesting medication. No medication was administered and she was referred back to her obstetrician.

On the day before Annie's death, Freda and James travelled with Annie by bus to run a number of errands and visit with relatives. They returned to the family home in the late evening and placed Annie in her infant car seat.

James stated that he went to bed in the early hours of the morning and did not notice Annie or Freda in the upstairs bedroom. He awoke to Freda's screaming just prior to noon.

Freda told police that when Annie had awoken, she removed Annie from the crib and placed her in the car seat downstairs.[39] When she later checked on Annie, Freda found her not breathing and unresponsive. Officers noted at the time that the crib was not suitable for a baby to sleep in, due to the number of clothes, blankets and toys that were in the crib.

Emergency medical services responded and transported Annie to a hospital, where she was pronounced dead.

[39] There were conflicting statements given to police about where Annie slept. It was not clear whether she was left in a car seat overnight or slept in her crib. She was in her car seat when Freda found her not breathing and unresponsive.

After Annie's Death

Following Annie's death, an autopsy was performed. She exhibited no physical signs of trauma, but it was noted that she had poor weight gain. Since birth, Annie had lost seven ounces (200 grams), which was considered abnormal. Cultures were positive for Klebsiella pneumonia[40], in her lungs and blood, which can result in sepsis (blood infection by bacteria). The Medical Examiner classified Annie's cause of death as "undetermined".[41]

The toxicology report revealed that Annie had trace amounts of Nordiazepam[42] and Oxazepam[43] in her system. The toxicologist stated that the presence of these drugs could be explained if Freda had used Diazepam drugs during pregnancy or if she had breastfed Annie after using Diazepam. According to all accounts and reports, Freda never breastfed.

Annie's four siblings remained in foster care for approximately three months after her death. They were returned to their parents' care under a six-month Supervision Order. At the end of the Order, Freda and James indicated they did not want any additional supports, and the child intervention file was closed.

Within a month, concerns were received by Child Intervention Services and police that Freda and James were not adequately supervising the children, who were all under 10 years of age. An assessment was completed and a Family Enhancement Agreement[44] was entered into with Freda and James.

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[40] Klebsiella pneumonia bacteremia is a relatively rare, serious infection that usually occurs in young children with predisposing underlying conditions and is associated with a significant mortality rate. http://www.ncbi.nlm.nih.gov/pubmed/2672784

[41] In Alberta, "undetermined" cause of death now encompasses those deaths previously classified as Sudden Infant Death Syndrome (SIDS).

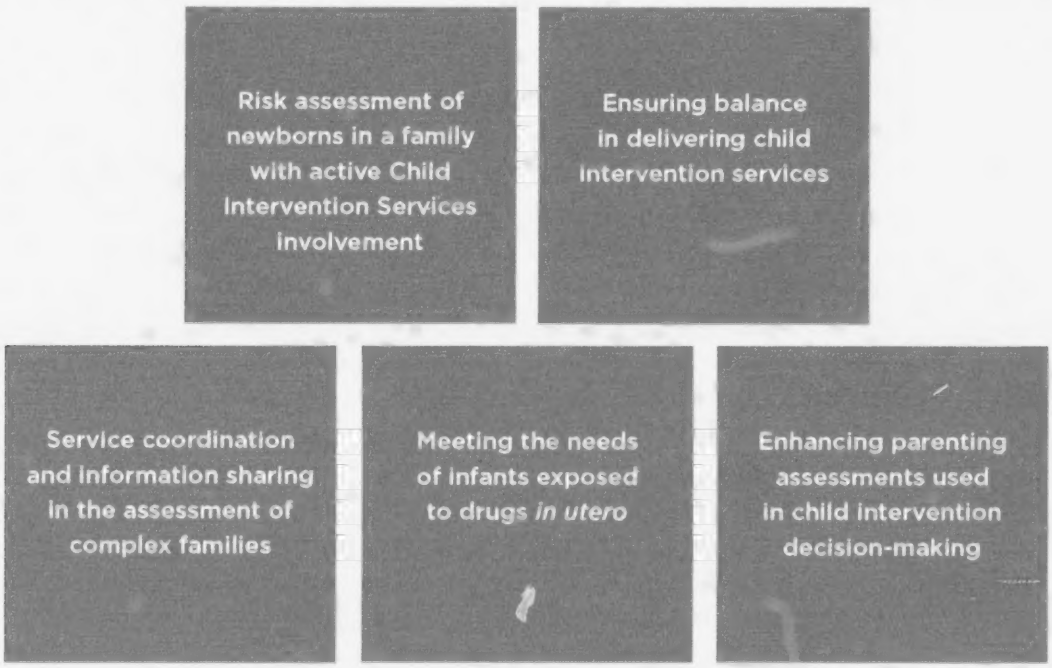
[42] Nordazepam (Nordaz, Stilny, Madar, Vegesan, and Calmday) is a benzodiazepine derivative and a metabolite of Diazepam. http://en.wikipedia.org/wiki/Nordiazepam

[43] Oxazepam (Alepam, Medopam, Murelax, Noripam, Opamox, Ox-Pam, Purata, Serax and Serepax) is a benzodiazepine derivative and a metabolite of Diazepam and Temazepam. http://en.wikipedia.org/wiki/Oxazepam

[44] Through a Family Enhancement Agreement intervention services are provided to a child and family by way of consent. The child's safety can be assured while in the care of the family/legal guardian. Guardianship and custody rests with the family/legal guardian.

DISCUSSION AND RECOMMENDATIONS

The information gathered through the investigative review process revealed a number of key issues related to practices and processes in the child intervention system:


Risk assessment of newborns in a family with active Child Intervention Services involvement
Ensuring balance in delivering child intervention services
Service coordination and information sharing in the assessment of complex families
Meeting the needs of infants exposed to drugs *in utero*
Enhancing parenting assessments used in child intervention decision-making

An analysis of these issues has revealed some systemic challenges. The goal is to learn from these to prevent similar issues occurring elsewhere in the systems that serve our vulnerable children.

Each key issue is discussed, along with recommendations designed to address these issues.

Risk Assessment of Newborns in a Family with Active Child Intervention Services Involvement

Risk assessment is a vital tool in determining the need for child intervention services and the form those services should take. Risk assessment involves the gathering of information and the application of critical thinking to consider a child's safety and well-being in the short-term and the long-term.

Through risk assessment, child intervention workers can determine the nature and likelihood of potential harm to children, and the protective factors that need to be in place for children. An examination of environmental factors (e.g., poverty), family factors (e.g., family stress level), caregiver factors (e.g., presence of substance abuse), and child factors (e.g., age of the child) should comprise part of the assessment to determine appropriate interventions.[45] A family's current strengths and challenges need to be considered, along with any history of child intervention involvement, particularly where there might be persistent patterns of behaviour or concerns that remain unresolved.

While assessment was used in this case, it was done reactively. Opportunities were missed to use assessment in a proactive way, especially considering the circumstances surrounding Annie's family and their history with Child Intervention Services.

James and Freda had a well-documented history of drug and alcohol abuse, family violence and transience. At the time of Annie's birth, four of their other children (Katie, Kyle, Cindy and Matt) were in foster care due to concerns related to these issues.

While her siblings remained in foster care, Annie was discharged from hospital and returned to the family home with her parents. A child intervention file was not opened until concerns were reported from the community. Only after concerns were received, was the matter opened to an assessment.

Annie's interests may have been better served by conducting a risk assessment prior to her discharge from hospital, taking into account the context of her entire family. In fact, it might have been preferable if planning had been undertaken with Freda and James prior to Annie's birth to ensure that services and supports were in place so they could be more successful in parenting their newborn child.

Recommendation #1

Child Intervention Services should institute policy that is proactive in planning for children and families when a newborn child is expected into a family that is receiving intervention services.

[45] DePanfilis, 2006

An additional concern relates to the scope of information that was used to inform the assessment in this case.

When Child Intervention Services received concerns after Annie's birth, the caseworker responsible for the case of Annie's siblings did not conduct the safety assessment. Instead, the task was assigned to an assessor who was unfamiliar with her family. Through the Advocate's Investigative Review, intervention staff emphasized the need to assess Annie's risk separately from the concerns that kept her siblings in care. It was felt that Annie's siblings' involvement with the child intervention system was "historical", and not a current factor that should be considered in Annie's assessment.

Child Intervention Services implemented the Casework Practice Model (CWPM) in 2007 to support continuous improvement of outcomes for children, youth and families. The CWPM manual states:

> *It is important that assessment shift from the gathering of facts to critical thinking about the information gathered... We need to search for patterns and themes, then check with those whom we assess to see if our analysis makes as much sense to them as it does to us.*[46]

Currently, training is being delivered to better enable child intervention staff to reflect upon and explain the rationale for decisions about how they work with families while ensuring children are kept safe. The *Child Intervention Practice Framework*[47] provides child intervention workers with methods they can use to test their assumptions about a family.

It is challenging to test assumptions in isolation, without taking into consideration the perspectives of others who are close to the situation. "Signs of Safety"[48] is currently being promoted as a practice approach to help address this. The objectives of the model emphasize engagement, critical thinking and enhancing safety. Author Andrew Turnell warns:

> *"The difficulty is that as soon as the professional decides they know the truth about a given situation this begins to fracture working relationships with other professionals and family members, all of whom very likely hold different positions. More than this the professional ceases to think critically and tends to exclude or reinterpret any additional information that doesn't conform to their original position."*[49]

[46] Alberta Children's Services, 2007

[47] Alberta Human Services, 2013

[48] Initially developed in Australia by Andrew Turnell and Steve Edwards.

[49] Turnell, 2012

At the time of Annie's birth, and during her short life, Annie's family received services from numerous sources including: financial assistance, in-home support, an obstetrician, a pediatrician, a therapist, a public health nurse, child intervention, Aboriginal community agencies, and addictions services. In addition, relatives were involved in supporting Annie's family. However, information was not gathered from this range of sources and there was little coordination of services. It would have been in Annie's interest, for all of these service providers to have come together to plan for and support Annie and her family.

Pushing the scope of assessment beyond the immediate family and including input from these various parties would have provided a more comprehensive assessment. This would have allowed a thorough picture to emerge of the past and present functioning of Annie's family while considering Annie's safety. Assumptions made following home visits could then have been tested against the perceptions of professionals and other service providers who also knew the family.

There is opportunity for the Ministry of Human Services to continue broadening the scope of the Child Intervention Practice Framework as a means of driving policy and/or practice changes that promote engagement, critical thinking and incorporation of stakeholders in the information gathering and analysis process. In doing so, the safety of children can be enhanced.

Ensuring Balance in Delivering Child Intervention Services

The issues of parental substance abuse and family violence were prevalent and longstanding in Annie's family. Throughout the history of the family's involvement with various support agencies, interventions largely centered on Annie's parents' alcohol and drug use. On occasion, the assessment or intervention file was closed with the parents' promise to not use drugs or alcohol while caring for their children.

Family violence issues, however went largely unaddressed, other than in some instances in which James had care of the children and was not to allow Freda unsupervised contact with them. An understanding of the cycle of violence and addictions was not explored with Annie's family. Interventions also focused almost entirely on Freda and James, rather than on the children or the impacts that exposure to violence and substance abuse had on them.

In a previous Investigative Review, *Remembering Brian*[50], the Advocate recommended the development of guidelines regarding parental addictions, and to fully examine and address the impacts that family violence and addictions have on children. The Advocate also recommended that a balance be struck between child-focused and family-centered approaches when delivering intervention services. Those

[50] Office of the Child and Youth Advocate, June 2013.

recommendations are relevant in this review as well. Action on the recommendations will enable Child Intervention workers to better assist parents in gaining an understanding of the issues that impact their children and in developing supports to address those issues.

Service Coordination and Information Sharing in the Assessment of Complex Families

Families with complex needs experience numerous, chronic and inter-related problems. By definition, these families typically have five or more disadvantages such as: living with poverty, family violence, substance abuse, financial problems, housing problems, criminal activity, child protection involvement, learning and intellectual disabilities. Families who face multiple barriers and life issues routinely become involved with a number of agencies and institutions. There is seldom one service provider that has all of the information required to see a complete picture of the family. Each provides a service depending upon its mandate to address an area of concern and typically works independently of other service providers. There is often a lack of information sharing among providers, and each provider often has limited knowledge about the actual scope of supports and services that are being provided to a family.[51]

In this situation, there was little or no sharing of information amongst service providers, and there was little or no coordination of services amongst the agencies involved with Annie's family. Agencies and providers worked independent of one another in delivering services and supports to Annie's family. At times they worked at odds with one another.

For example:

- Freda was able to use repeat prescriptions to obtain medications even while child intervention workers and addiction services simultaneously attempted to address her issues around prescription drug abuse.
- Information about Freda's drug use - and the risks posed to Annie's health - was not shared between service providers until after a public health nurse had already completed a home visit, and well after Freda and Annie had been discharged from the hospital.
- Information about Child Intervention Services' involvement with Annie's family was not shared with health care professionals who were also providing services to Annie's family.
- Although Freda had informed community agencies she was pregnant during her first trimester, Child Intervention Services were not informed and were unable to proactively prepare for the upcoming birth.

[51] Bromfield, Sutherland & Parker, 2012

- Child Intervention workers viewed Annie's release from hospital as an indicator that hospital staff did not have concerns about her health or safety. Medical professionals were in fact concerned about Annie's well-being but these concerns were not communicated until after Freda and Annie were discharged.

Although it appears that the right supports for Annie's family were largely in place at any particular time, there was no common thread linking them together.

With little collaboration and information sharing, those involved with Annie's family made decisions and took actions that were different than they otherwise might have been. Through this Investigative Review, service providers spoke about feeling frustrated by limited information sharing due to a lack of trust between organizations and a lack of clarity about what information could be shared by whom.

Clearer guidelines have recently been provided with the proclamation of the *Children's First Act* on January 1, 2014.[52] Section 4 of the *Children's First Act* addresses "Information sharing for purposes of providing services". In addition, the Government of Alberta is expected to implement an Information Sharing Strategy over the next two years. Phase one is expected to include the Ministry of Human Services, the Ministry of Health and the Ministry of Education, along with their stakeholders and partners.[53]

Even with the authority provided under the *Children First Act*, and the support of an Information Sharing Strategy, there is a need for Alberta's systems and service providers to change their approach. A shift from a compartmentalized view of service delivery to a multi-service response is required.[54]

The further development of frontline, multi-service teams such as the Alberta Vulnerable Infant Response Team (AVIRT)[55] would enable service providers to address potential mandate conflicts and communication gaps and to deliver collaborative services to those in need.

It is important to note that successfully making the shift to a multi-service response will require support at all levels of participating organizations. It may also require the Government of Alberta to leverage its policy and financial levers in ways it has not

[52] *Children First Act*, S.A. 2013, c. C-12.5

[53] MacDonald, 2013

[54] Bromfield, Sutherland and Parker, 2012

[55] The Alberta Vulnerable Infant Response Team (AVIRT) is a collaborative response to assessing at risk infants who are under four months old. Alberta Heath Services, police and Child Intervention Services are working together to deliver this core service. AVIRT only assesses if there is no present involvement with Child Intervention Services.

considered before. For example, in this situation, Freda was able to visit 11 different physicians who collectively prescribed thousands of pills. In the future, a consent to release medical information could be used to empower Child Intervention Services to gather information from each care provider and pharmacy (e.g., via a review of the Statement of Benefits Paid for the mother and father).[56] This would better position child intervention workers to make decisions and take actions in support of a family and in protection of a child.

It was brought to the Advocate's attention that an External Expert Review Panel regarding the death of a young child (2011)[57], made a recommendation that Child Intervention Services and Alberta Health Services should work together to develop protocols, effective relationships and communication pathways, to enhance interdisciplinary and inter-system cooperation and collaboration, and develop a shared mandate for the well-being and safety of vulnerable children. The Ministry of Human Services has indicated that this recommendation has been accepted and completed. However, this approach was not evident in Annie's case. Therefore, the Advocate is making the following recommendation which must be acted upon.

Recommendation #2

The Ministry of Human Services should work with Alberta Health Services to implement a provincial, multi-service response model that enables collaborative and joint response to families with at-risk children who are involved with Human Services and Alberta Health Services.

[56] Such a consent would only be sought in circumstances where the need to protect the child outweighs the privacy interest of the parent and would likely be time-limited.

[57] Rogers, Findlay, McDonald, Scott and Wallace, 2011

Meeting the Needs of Infants Exposed to Drugs *in Utero*

Neonatal abstinence syndrome (NAS) refers to medical complications that can occur in newborns who have been exposed *in utero* to addictive prescription or illegal drugs. It can have significant effects on their respiratory, gastrointestinal and central nervous systems.[58]

These problems are most likely to occur within the first ten days of an infant's birth. It is vital that the newborn infant and the mother not be discharged from hospital too early, so that the baby can be monitored. Additional services may also be required to support the family prior to discharge. Research in this area recommends that potentially affected newborns be examined by a pediatrician to determine if there are signs of withdrawal or feeding problems, and to monitor weight gain.[59] [60]

In this situation, Freda and Annie were discharged from the hospital only 17 hours after Annie's birth. While hospital staff advised Freda not to breastfeed, there was no indication that the pediatrician who examined Annie prior to discharge was aware of the full extent of Freda's prescription drug use. It was not until after discharge that a letter was placed on Annie's medical file indicating concerns about Freda's prescription drug use, her ability to parent her newborn infant and the need for Annie to be seen by a pediatrician within seven days of discharge.

The different service areas that respond to infants at risk of NAS tend to focus on the services they deliver. Child Intervention Services focuses on assessing risk according to their mandate. The health system also has protocols for newborns which can result in a practitioner making independent decisions about what is required for an at-risk infant. The clinical practice guideline for substance use in pregnancy, approved by the Council of the Society of Obstetricians and Gynecologists of Canada, makes no mention of a multidisciplinary approach to support the newborn and family.[61]

As discussed earlier, a lack of coordination and information sharing between professionals and agencies hampered the ability of service providers to assess risk to Annie and effectively support her and her family. Better information sharing and a multi-service response would have been beneficial.

The development of a multidisciplinary protocol for newborns exposed to drugs *in utero* could assist in providing a coordinated response in situations such as Annie's. This would allow for professionals to work with a family to develop a care plan that ensures that medical, child safety, addiction treatment and other support needs are met.

[58] Johnson, Grenada & Greenough, 2003

[59] Kandall, 1993

[60] Hudak, Tan, the Committee on Drugs & the Committee on Fetus & Newborn (2012)

[61] Wong, Ordean & Kahan, 2011

Recommendation #3

The Ministry of Human Services and Alberta Health Services should establish policy and protocols to ensure sufficient information sharing[62] and a collaborative, timely (prior to discharge) response for infants at risk from Neo-Natal Abstinence Syndrome.

Through this investigative review, concern has been raised for infants who have been exposed to drugs *in utero*. But, further it makes sense to prevent infant drug exposure in the first place.

The ease with which Freda was able to obtain multiple prescriptions over an extended period of time is a serious concern. She obtained prescriptions in the absence of visits with her family physician. Had Freda been required to see her physician, the physician might have learned of her pregnancy and dealt with the medication requirements in a different manner. In addition, Freda obtained prescriptions from ten other physicians during her pregnancy and the majority of her prescriptions were filled at one pharmacy.

The College of Physicians and Surgeons of Alberta (CPSA) highlight the concern of multi-doctoring and codeine and benzodiazepine prescribing:

> *"Accessing Pharmaceutical Information Network (PIN) on NetCare is a simple way to monitor codeine use and to detect multi-doctoring that may be relevant to your patient management. Physicians may also begin to receive feedback from the CPSA regarding potential safety concerns related to their codeine and benzodiazepine prescribing."*[63]

As of July 2013, the College of Physicians and Surgeons of Alberta and the Alberta College of Pharmacists encouraged physicians to collaborate with other physicians and with pharmacists in developing plan of action for high-risk patients. Medications monitored will include codeine containing medications and benzodiazepine once the 2013 data is available.[64] [65]

[62] Public bodies involved would likely be required to have a formal information sharing agreement and such sharing of information would have to be in compliance with the *Freedom of Information and Protection of Privacy Act*.

[63] College of Physicians and Surgeons of Alberta, January 2013

[64] College of Physicians and Surgeons of Alberta, November 2012

[65] College of Physicians and Surgeons of Alberta, July 2013

Recommendation #4

The College of Physicians and Surgeons and the Alberta College of Pharmacists should review the effectiveness of the Pharmaceutical Information Network (PIN) to detect and flag multi-doctoring and potential safety concerns related to codeine and benzodiazepine prescriptions, with a view to preventing fetal exposure to these medications.

Enhancing Parenting Assessments Used in Child Intervention Decision-Making

Psychological parenting assessments are frequently used as a tool to inform child intervention case planning. They are also relied upon as evidence in court when child intervention applications are contested by parents.

In the region where this incident occurred, the practice was to provide the contracted assessment professional with background information which outlined the family child intervention involvement. Interviews and a series of test questionnaires were completed with the parents at the professional's office. The questionnaires help identify the parent's emotional state, child-rearing style, social supports, adaptability, academic functioning, personality profile, and how the parent responds in a family context.[66] The professional provided a report summarizing the parent's strengths and challenges, and made recommendations about the parents' ability to care for their children.

This practice varies across regions. Some regions might require professionals to meet with the parents in their home environment or that the children be present for some of the meetings. Sometimes multiples meetings are required in various environments.

Both James and Freda underwent parenting capacity assessments during the year prior to Annie's birth. James' assessment was completed nine months before Annie's birth and was based on interviews and tests conducted over two appointments. Freda's assessment was completed approximately four months before Annie's birth and consisted of an interview and testing conducted during one appointment. Prior to the parenting assessment, Freda also accessed individual therapy through a counseling agency.

James' assessment noted that he had difficulty taking responsibility for problems in his life. Because of this, it was felt that referring James for addictions treatment would not be helpful. Further, it was suggested that an in-home parenting coach would be beneficial.

Freda's assessment noted that she needed education and support in several areas, including child development. She was overwhelmed with parenting and felt anger and frustration. It was recommended that she be involved in a program to address the domestic violence she had experienced with James.

[66] Budd, 2001

Parenting capacity assessments are often limited to conversations, tests and questionnaires with parents. Research has questioned the worth of parenting assessments that are based solely on these types of activities.[67] The American Psychological Association emphasizes the need for parenting assessments to be informed by an observation of the parent with their children, as well as an understanding of each child's needs.[68] Depending on the needs of each child, parenting risk within a family can vary to the point where one child might be receiving adequate care while another might not.[69]

Studies have also placed value on drawing information from sources other than solely the caseworker and the parents. Teachers, therapists, health professionals, foster parents and visit supervisors are examples of additional sources of information that a psychologist can access in conducting their assessment. This information can then be brought back to the parents for their response when they are being interviewed as part of the assessment.[70]

The parenting assessments that were conducted with Freda and James did not take into account sources of information other than the parents and the referring caseworker. They did not involve observation of either parent with their children. They did not consider the unique needs of each child in the family in relation to either parent's strengths or challenges.

Through the Investigative Review, it became apparent that the child intervention system adopted a view that Freda was challenged in her ability to parent and reluctant[71] to address those challenges, but that James was capable and the children would be safe in his care (so long as he did not leave the children alone with Freda). This perspective seems to have been influenced more by personality than by

[67] Budd, 2001

[68] American Psychological Association, 2012

[69] Choate, 2009

[70] Choate, 2013

[71] A resistant and/or reluctant client is likely not to engage in the change process or have a working relationship with the helping professional involved. They may present themselves as not needing help, terminate the process at the earliest possible moment and not follow through on agreed upon actions. This may be for different reasons such as feeling overwhelmed by many issues, lack of trust with a system or emotionally not able to deal with past and present issues.

objective assessment. While James may have been less resistant, more personally engaging and easier to deal with than Freda, he nevertheless presented several risk factors. James refused to acknowledge and deal with his substance abuse; he had been involved with the criminal justice system; and, he became easily frustrated with his children.

It is likely that a more complete picture of Freda's and James' parenting abilities would have emerged if the parenting capacity assessments had been more comprehensive.

A further concern related to parenting capacity assessments is whether they deal with differences across cultural or social environments. Research on the use of psychological testing with Aboriginal families in Australia notes, "Psychological theory and practice has been founded on the understanding of human behaviour in modern westernized cultures."[72] This study challenges the effectiveness and validity of psychological testing when it is applied cross-culturally.

The Australian research raises questions about the parenting assessment process used by Alberta's child intervention system when the parents are from different cultural backgrounds. Both Freda and James were of First Nations heritage. The results of their parenting capacity assessments might have been different had the assessment process accounted for indigenous cultural practices.

As there is a significant representation of Aboriginal people involved with Alberta's child intervention system, it is important to examine how parenting assessments could be enhanced to take into account differences amongst parents and families who come from a First Nations or other Aboriginal cultural background.

Recommendation #5

(a) Child Intervention Services should review how parenting capacity assessments are conducted across the province and implement policy that ensures parenting assessments are done in a consistent manner and are comprehensive in nature.

(b) Child Intervention Services should ensure that parenting norms unique to First Nations and other cultural groups are incorporated into parenting capacity assessments.

[72] Ralph, 2011

CLOSING REMARKS FROM THE ADVOCATE

The Child and Youth Advocate wishes to thank and acknowledge all of the individuals who contributed to this Investigative Review. The review has generated strong feelings among everyone concerned. As well, it is important to acknowledge the life changing impact for the family from this tragedy.

During this review, we were frequently reminded of the struggles for children and families in these circumstances. As well, we saw the real challenges professionals face in their efforts to achieve significant progress with them. We know that working consistently, communicating collaboratively and taking proactive action are critical to this work. But, we must also acknowledge the difficulties in this work for all concerned. The systems that serve children and families must constantly strive to reduce these difficulties, and to increase the supports needed for significant progress to be achieved.

This review was about an Aboriginal infant who was born into a family with significant challenges. Annie's short life poignantly demonstrates the importance of taking a comprehensive view when assessing family dynamics and the potential risk posed to children. When we seek out a range of viewpoints, share what we know, collaborate with with colleagues, and take action consistent with our purpose, we can improve results for children. It is my hope that full implementation of the recommendations from this review will improve the outcomes for children in similar circumstances.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

APPENDIX 1: TERMS OF REFERENCE

Incident

14-day-old Annie was found unresponsive in her home and pronounced dead at the hospital. The Medical Examiner indicated the cause of death to be "undetermined". Postmortem examinations revealed possible sepsis (blood infection by bacteria), pneumonia, a positive infant drug screen for benzodiazepine[73] (valium) due to maternal prenatal use and poor weight gain.

At the time of her death, Child Intervention Services was completing a Safety Assessment.

Authority

Alberta's Office of the Child and Youth Advocate is an independent office reporting directly to the Legislature of Alberta. The Child and Youth Advocate derives his authority from the *Child and Youth Advocate Act*. The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act*, the *Protection of Sexually Exploited Children Act* or from the youth justice system.

Section 9(2) (d) of the *Child and Youth Advocate Act* provides the Advocate with the authority to "investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest".

The Initial Assessment took longer to complete than expected as the child's intervention files were requested and received in two phases; and, due to the complex nature of the family's historical involvement with intervention services. The decision to conduct an investigation was made by Del Graff, Child and Youth Advocate.

[73] Benzodiazepine is a class of psychoactive drug that is used for treating anxiety and insomnia. If used during pregnancy it may cause harm to the fetus.

Objectives of the Investigative Review

To review and examine the supports and services provided to Annie related to:

- Risk assessment and child protective services:
  - The family had extensive child intervention history and the older children were in the care of the Director at the time of Annie's birth. How was the historical information and risk factors considered in completing an analysis and ensuring an infant's safety?
- Service coordination:
  - The older children were receiving intervention services and there was a caseworker familiar with the family; however, an assessor who was unfamiliar with the family was assigned to Annie.
  - A specialized resource, the Alberta Vulnerable Infant Response Team (AVIRT) could not become involved due to regional policy.
- To comment upon relevant protocols, policies and procedures, standards and legislation.
- To prepare and submit a report which includes findings and recommendations arising from the investigative review.

Scope/Limitations

An Investigative Review does not assign legal responsibilities, nor does it supplant or abrogate other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals, but to identify and advocate for system improvements that will enhance the overall safety and well-being of children who are receiving designated services.

Methodology

The investigative process will include:

- Examination of critical issues;
- Review of documentation and reports;
- Review Enhancement Act Policy and casework practice;
- Review of case history;

- Personal Interviews:
  - Caseworkers,
  - Family members,
  - Medical and mental health service providers,
  - In-home support service providers,
- Consultation with experts as required;
- Other factors that may arise for consideration during the investigation process.

Investigative Team

- Lead investigator: Office of the Child and Youth Advocate
- Secondary investigator: Office of the Child and Youth Advocate

Investigative Review Committee

The membership of the committee will be determined by the Director and the Advocate. The purpose of convening this committee is to review the preliminary investigative review report and to provide advice regarding findings and recommendations.

Chair

- Del Graff, Child and Youth Advocate

Members (To be determined but may include):

- An Aboriginal Elder
- An expert in the area of adult addictions
- A pediatrician
- A specialist in the area of child welfare best practices

Reporting Requirement

The Child and Youth Advocate will release a report when the investigative review has been completed.

APPENDIX 2: COMMITTEE MEMBERSHIP

Del Graff, MSW, RSW (Committee Chair)

Del is the Child and Youth Advocate for the Province of Alberta. He has worked in a variety of social work, supervisory and management capacities in communities in B.C. and Alberta. He brings experience in residential care, family support, child welfare, youth and family services, community development, addictions treatment and prevention services. He has demonstrated leadership in moving forward organizational development initiatives to improve service results for children, youth and families.

Walter (Wally) Sinclair

Wally Sinclair is the president of the Lac La Biche Friendship Centre and the National Board representative for the Alberta Native Friendship Centers Association. Raised in Lesser Slave Lake, Alberta, Wally is a member of the Sawridge First Nation. He has extensive experience working with federal, provincial and regional governments, and has worked in addictions counselling and in health services as a director and specialist in the field to ensure cultural competency and awareness. He completed studies at the University of Alberta and earned a Local Government certificate as well as Addictions and Therapy certificate. Wally was recently appointed to Alberta Health Services' Aboriginal Wisdom Circle and was awarded the Queen Elizabeth II Diamond Jubilee Medal.

Andrea Kennedy, PhD

Dr. Andrea Kennedy grew up in a family that is culturally diverse, and her paternal grandmother is of Mohawk Ancestry. She worked as a registered nurse for over 20 years at the Alberta Children's Hospital. In 2005, she began teaching undergraduate nursing students as a professor at Mount Royal University (MRU). Andrea is involved in collaborative work with the MRU Indigenous Health Community of Practice, MRU Centre for Child Well Being, Alberta Children's Hospital and Bridges Social Development 'Unveiling Aboriginal Youth Potential' program. She is a member of the Aboriginal Nurses Association of Canada, a council member for the Wisdom Council, Aboriginal Health Program and FIRST Nations Women's Economic Security Council, Aboriginal Relations, Government of Alberta. Andrea is dedicated to exploring strengths and solutions that promote indigenous health and well-being for individuals, families and communities.

Peter Choate, PhD, RSW

Dr. Peter Choate is an Assistant Professor of Social Work at Mount Royal University. He is an expert witness in the area of parenting capacity (including risk, domestic violence, and addictions). He has been qualified on multiple occasions in the Provincial Court of Alberta (Edmonton, Calgary, Red Deer) and the Court of Queen's Bench (Calgary and Medicine Hat). He teaches and writes about parenting capacity at workshops, conferences and as a professional development instructor at the University of Calgary.

Christine Walsh, PhD

Dr. Christine Walsh is an Associate Professor in the Faculty of Social Work at the University of Calgary and holds an adjunct assistant professorship at McMaster University. Christine was employed as a clinical social worker at McMaster Children's Hospital where she conducted parenting assessments and maltreatment evaluations as part of a multidisciplinary team. She also worked at the Oxford Centre for Child Studies as a research associate, investigating the epidemiology of child maltreatment, women's mental health and Aboriginal health. Her research interests involve contributing to the understanding of violence across the lifespan and populations affected by social exclusion, poverty and homelessness. Christine has publications in a variety of journals and is involved a number of research projects. She is a founding member of the Downtown Community Initiative in Calgary, a core member of the research team for the Child Development Centre and an executive member of the Child and Maternal Health Institute.

Lionel Dibden, MBBCh, FRCP(C)

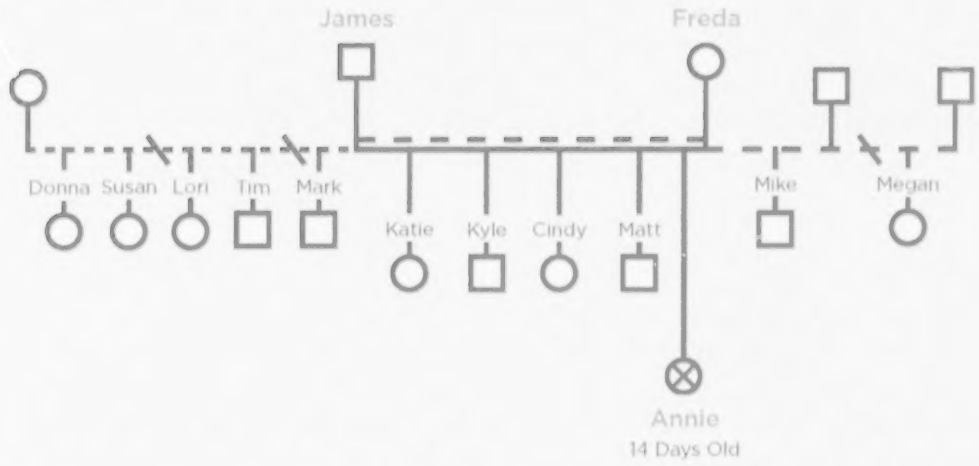
Dr. Dibden works in the field of child maltreatment and is currently an Associate Professor at the University of Alberta in the Department of Pediatrics. He participated in the development and implementation of the Child and Adolescent Protection Centre (CAP Centre) at the Stollery Children's Hospital. Operational since 1999, the Centre's main purpose is to provide a coordinated and collaborative response to child abuse. Dr. Dibden works with the children in clinic where his calm and caring nature provides children with a safe environment for their medical assessment.

Dr. Dibden has also served as the Chair of the Child and Family Services Council for Quality Assurance with the Ministry of Human Services. The Council is a multidisciplinary body of experts who work with the Ministry to identify effective practices and make recommendations to the Minister for improving and strengthening child intervention services.

Dr. Dibden has played a role in the education of medical students, medical professionals, staff working in law enforcement and Children's Services, and crown prosecutors in the area of child abuse. He has testified as an expert witness in many cases of child maltreatment.

APPENDIX 3: GENOGRAM

Annie's Genogram



Legend

Male Female Death

Legal cohabitation and separation in fact

Committed relationship

Committed relationship and separation

APPENDIX 4: SUMMARY OF SIGNIFICANT EVENTS

APPENDIX 5: SUMMARY OF MEDICATIONS

Codeine Medications are used to treat mild to moderate pain. The codeine can cause physical and psychological dependence. They are quickly converted by the body into morphine, so those with addiction issues are cautioned around their use. Health Canada has published a warning advising that women who are pregnant or breastfeeding should not use prescription or non-prescription drugs with codeine. *(http://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2013/33915a-eng.php)*

- **Tylenol 3 (codeine) -** 2107 tablets issued during gestation; 99 issued during Annie's life. *(http://www.medbroadcast.com/drug_info_details.asp?brand_name_id=1542)*
- **Acetaminophen (caffeine & codeine) -** 1450 tablets issued during gestation.
- **APAP (caffeine and codeine) -** 200 tablets issued during gestation.
- **Ratio Cortridin Syrup (codeine, triprolidine, pseudoephedrine) -** 600 ml dispensed during gestation.

Benzodiazepines have a sedative, hypnotic effect and are used to treat anxiety, insomnia, agitation, seizures, muscle spasms and as a premedication for medical procedures. Long-term use can invoke physical and psychological dependency as well as withdrawal symptoms when use is stopped. They are known to cause withdrawal symptoms in newborns and there are not for use during pregnancy or while breast-feeding. *(http://en.wikipedia.org/wiki/Benzodiazepine)*

- **Diazepam (Valium) -** 678 x 10MG tabs issued during gestation; 63 issued during Annie's life. Used to treat anxiety disorders. It should be taken for short periods only, around 2 to 4 weeks. *(http://en.wikipedia.org/wiki/Diazepam)*
- **Temazepam (Restoril) -** 309 x 30MG caplets issued during gestation; 21 issued while Annie was alive. Used for sleeping problems and is to be used for 7 to 10 days. *(http://en.wikipedia.org/wiki/Temazepam)*
- **Lorazepam (Ativan or Orfidal) -** 40 x 1mg tablets dispensed during gestation. Used to treat symptoms of excessive anxiety. *(http://en.wikipedia.org/wiki/Lorazepam)*
- **Nordazepam (Nordaz, Stilny, Madar, Vegesan, and Calmday) -** Trace amounts found in Annie's system after she passed away. A benzodiazepine derivative and a metabolite of Diazepam. *(http://en.wikipedia.org/wiki/Nordiazepam)*

- **Oxazepam (Alepam, Medopam, Murelax, Noripam, Opamox, Ox-Pam, Purata, Serax and Serepax) -** Trace amounts found in Annie's system after she passed away. A benzodiazepine derivative and a metabolite of Diazepam and Temazepam. *(http://en.wikipedia.org/wiki/Oxazepam)*
- **Bromazepam (brand name Lectopam) -** File indicates historical consumption but not dispensed during gestation with Annie. Used in the short-term treatment of anxiety or panic attacks or for premedication before surgery. *(http://en.wikipedia.org/wiki/Bromazepam).*

Other Drugs

- **Ado-Dymenhydrinate –** 130 x 50MG tablets dispensed during gestation. An antihistamine used to treat nausea but is abused recreationally for its sedative effect. *(http://en.wikipedia.org/wiki/Dimenhydrinate)*
- **Robaxacet (Methobarmol) -** File indicates historical consumption. Available without a prescription for relief of back pain. It has a sedative effect which, when abused can be similar to Lorazepam (see above). *(http://en.wikipedia.org/wiki/Methocarbamol#Abuse_potential)*

APPENDIX 6: REFERENCES

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BABY ANNIE: AN INVESTIGATIVE REVIEW